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ABSTRACT

Health policy researchers have long been interested in the extent to which the provision of formal supports replaces or undermines the informal support system. This study examined the linkages between the formal and informal support system as they are mediated by a health care setting which readily provides patients with access to social services. Subjects (N=200) were ambulatory and alert adults over age 65 who were patients at general medical clinics. Subjects were interviewed about health status and health care and social service utilization, as well as their activities with and supports from members of their families and friends. To assess the relationship between formal and informal sources of support, data were examined on the subjects' need for support, their family relationships, and their use of community services. The results indicated that support from the family was not necessarily forthcoming. The receipt of formal services in this population was based upon need as measured by living alone and being functionally impaired, and not upon family variables. Most had inadequate family resources, with few subjects married and many with no children in the immediate area. In summary, high use of formal services was associated with high needs. Family involvement was not significantly associated with use of formal services. (ABL)

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DO FORMAL SUPPORTS REPLACE INFORMAL SUPPORTS?

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DO FORMAL SUPPORTS REPLACE INFORMAL SUPPORTS?

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Health policy researchers have long been interested in the extent to which the provision of formal supports replaces or undermines the informal support system. Lawmakers and policy-makers often express concern that families might choose to revoke their responsibilities, thus shifting the burden of care to expensive formal programs.

These prevailing concerns are expressed even though national research to date has consistently found that family members provide much of the social support required by their older relatives (Shanas, 1979; Johnson & Catalano, 1983). Families commonly perform specific caregiving tasks, or act as mediators with bureaucratic systems (Sussman, 1977; Noelker & Bass, 1989). The literature further suggests that family members have the capacity to act as case managers, providing the linkage between the formal and informal support network (Seltzer et al., 1987). Class and ethnic differences are not usually addressed, so it is unclear whether such family supports are also found among poor urban families. The purpose of this paper is to examine these issues using data on 200 community-dwelling elderly individuals who are predominantly from racial minorities, economically

disadvantaged, functionally impaired and in need of social support.

THE STUDY

The findings reported here are from a study designed to examine the linkages between the formal and informal support system as they are mediated by a health care setting which readily provides patients with access to social services. The respondents in this study receive comprehensive medical care from clinics which not only monitor chronic health conditions, but also evaluate social needs and make referrals to appropriate services. The ensuing results are high rates of utilization of both health care and community social services.

Two hundred respondents, aged 65 and over, were randomly selected over a 12-month period from patients seen at the general medical clinics of two inner-city San Francisco hospitals. The sample was limited to those elderly who were ambulatory and cognitively alert enough to participate in the study. The interview format combined both open-ended and structured questions. In-depth home interviews elicited discussions of the respondent's health status, health care and social service utilization, as well as their activities with and supports from members of their family and friends. In order to verify respondent's reports on utilization, the patients' medical charts were reviewed to record the number of clinic visits and social service referrals made.

To assess the relationship between formal and informal sources of support, data were examined on the subjects need for support, their family relationships and their use of community services. Health and functioning were evaluated by the Activities of Daily Living (ADL) and the Instrumental Activities of Daily Living (IADL). Self-reports of the subjects' health status were gathered in addition to the review of their medical charts. Social support was evaluated by three variables: 1) frequency of contact; 2) receipt of instrumental and expressive aid; and 3) the potential availability of relatives to help if the need arises in situations such as bringing in groceries or assisting during a period of recuperation.

Table 1

Table 1 summarizes the characteristics of the sample. One can observe that a large portion are in need of supports, and as an aggregate, meet the description of the "vulnerable" elderly who are at risk of institutionalization. Their mean age is 73, the majority are unmarried, live alone, and have limited income. Half (51%) receive SSI benefits and 60% are Medicaid patients. Of the sample of 200, 65% are black and 10% are members of other minority groups. In terms of their needs, a little over half report their health to be fair or poor, 42% are impaired on 3 or more Activities of Daily Living and many complained of pain, low energy, restriction on activity and problems with sleeping.

In addition to the predominance of unmarried individuals living alone, the fact that one-third are childless and almost one-half have no children in proximity obviously limits the availability of family to activate for support. Simply in terms of frequency of social contact, only 41% see a child or other relative, including grandchildren, at least weekly and 18% have weekly contact with a sibling. A large proportion of the respondents are in frequent touch with friends or participate in organized activities such as church groups, senior centers or community activities.

INFORMAL SUPPORTS

Table 2

Table 2 reports on social supports received by this sample of inner-city elderly, by percentages. Social contact is measured by frequency of face to face contact. Support from informal sources is measured by whether or not instrumental and/or expressive supports are provided by each category of relationship (spouse, child, sibling, relative and friend). In the provision of instrumental supports, we find a large portion do not receive supports from primary relatives, that is, a spouse or child. Very few can count on a spouse, sibling or other relative to help with tasks and even less than one-third have instrumental needs met by children, the same proportion as those who have needs met by friends or neighbors. Over one half of the sample report having contemporaries to whom they can turn for expressive

support. Family members are a little more prepared or able to meet the emotional needs, compared with the instrumental needs, of this older generation. About one-third receive support from a child, sibling or relative. Among those few who are married, expressive support from their spouse seems to be forthcoming.

Since not all respondents needed supports at the time of the interview, we asked to whom they could turn for help should the need arise. Few expect help. One-third would expect a child or friend to call if they were sick, but only 12 - 14% expected others such as siblings or other relatives to call. Even fewer expect more objective help. Only one-fourth report a child would bring in groceries, 14% mentioned other relatives and 28% had a friend they could turn to for this task. This potential support diminishes dramatically when the possibility of requiring help during a period of recuperation occurs.

FORMAL SUPPORTS

Comparisons of formal supports and informal supports when accounting for the patient's level of impairment are reported in Table 3. Group 1 consists of individuals who have no impairment or are impaired on one to two items on the Activities of Daily Living (ADL/IADL). Those in group 2 are impaired in performing three or more of the Activites of Daily Living. With regard to the amount of social contact experienced, there is no statistically significant difference

between the two groups. Table 3 indicates that both the formal and informal support system is more active with the more functionally impaired except in the reduced instrumental support provided by spouses and friends. This may be explained by the limitations imposed on these age peers by the likelihood of their own incapacities which would hinder their ability to provide a greater level of support when needed.

In the use of formal services, statistically significant differences were found with the more impaired group showing higher use of social services. There is a much more significant relationship between the use of formal supports and the more impaired group particularly in the use of home choreworkers and, secondarily, transportation. Services provided at home by the Visiting Nurses Association, were also statistically significant, but those contacts were usually short-term and for acute episodes. Notably only 7% of the population participate in adult day health care programs or are served by comprehensive case management. Taking all services into consideration, the less impaired group has a mean use of .655 compared with a mean use of 2.5 formal services by those impaired on 3 or more ADL.

Table 3

Most commonly prescribed among the formal services is home health care, with one-third of the sample obtaining assistance which ranges from a few hours a week to several

hours of support daily. Subsidized senior transportation mobilizes 27% of the population. These two services in combination are the most indicative of how formal services can facilitate community living among chronically impaired, elderly. Utilization of these services is highly correlated with being single, living alone and reporting poor health with a high degree of functional impairment.

A further analysis of the data shows the positive effects of receiving services, such as home care and transportation. Their provision enables this population to function more or less independently in the community. Our findings confirm those reported by Greene (1983) where "statistically the most significant single predictor of level of formally provided support is seen to be the level of ADL impairment." More impaired individuals receive more formal support and the amount of services provided is not correlated with family support.

Furthermore, contrary to what has been suggested elsewhere, it was found that with this population formal services are rarely initiated through family insistence or intervention. Rather it is through the Clinic that patients are linked to available social service programs. Sixty-five percent of the referrals for formal services were made by the medical clinics, while a mere 2% of services were arranged by a family member. Not only are most of these inner-city elderly eligible for services through federal funding, but as

outpatients in these hospital clinics, their needs are systematically evaluated and referrals are readily made. In other words, services are prescribed. With most patients qualifying for Medicaid and SSI, even the personal financial responsibility for meeting the costs of these services is eliminated.

These clinic patients benefit not only from accessing services through their health care system, but they are further spared the bureaucratic tangles of negotiating and paying for services since the clinic manages all the paperwork. Thus the role of the clinic is primary in recognizing, documenting and validating the need for services, prescribing services and following through with referrals to appropriate providers.

It is possible to further explore the use of formal services through regression analysis. Table 4 consists of a forced regression on the use of social services, a variable which includes the total of all formal services used in the previous year.

Table 4

This analysis is based on the conceptual framework outlined by Andersen (1968) whose behavioral model of health services utilization includes need characteristics, predisposing characteristics and enabling characteristics. Our method of conducting in-depth interviews and reviewing health records of responsdents provided a comprehensive set

of indicators for each set of the predictors in Andersen's model. Need was operationalized by the four measures of self-reported health (a four-point scale with 1 = excellent); number of hospitalizations in the previous year; evaluation of ADL/IADL (both scores combined) and the scant amount of help provided by family on items of impairment on the ADL/IADL.

Enabling characteristics were measured by the adequacy of income on a three-point scale, with very adequate = 1; number of clinic visits (which link a patient with social services), and satisfaction, which is a composite score of satisfaction with health care, social services and informal supports, with 1 = satisfied and 0 = other. The predisposing characteristics of the sample were operationalized with five demographic measures, specifically age, gender (male = 1, female = 2), race (black = 1, other = 2), marital status (married = 1, other = 0), and household structure (living alone = 1, other = 0).

In accordance with Andersen's conceptual model we analyzed the use of social services by a forced regression entering predisposing characteristics first, entering enabling characteristics at the second step and entering the need characteristics last. The findings indicate that the use of formal supports is strongly related to needs as measured by impairment with the ADL and IADL. Living alone also is significantly associated with use of formal services. Being

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satisfied with all sources of support also contributes significantly to use of formal supports. These three variables contribute to 55% of the variance in the use of formal services. It is interesting to note that family assistance with those impaired on Activities of Daily Living is not significant.

CONCLUSION

In exploring the social supports received by inner-city impaired elderly, it is evident that support from the family is not necessarily forthcoming. The receipt of formal services in this population is based upon need as measured by living alone and being functionally impaired, and not upon family variables. Most have inadequate family resources - few respondents are married and many have no children in the immediate area. Where there are family members in proximity, the discussions in the interviews suggest that many are often struggling with their own impoverishment and frequently disrupted lives. Such troubles undoubtedly leave them with little energy or incentive to make a long term commitment to a chronically ill older relative. The hazards and vagaries of inner-city life take a toll on generational relations.

For the older generation, this toll is greatly alleviated by the provisions of federal income assistance through SSI and health care coverage by Medicaid which also makes them eligible for comprehensive social services. As one respondent said, "I have food and a roof over my head and

good medical care. I am blessed." With such provisions individuals can maintain their financial independence and not be compelled to involve their fragile families. Since formal social services can sustain community living, premature institutionalization of these vulnerable elderly can be avoided. Our analysis suggests that for this at-risk population the burden of care is not being shifted from available informal providers to formal programs. Instead the provision of formal supports serves to sustain community living and forestall premature institutionalization.

In summary, high use of formal services is associated with high needs. Family involvement is not significantly associated with use of formal services. These findings suggest that once an individual reaches a particular level of need and is absorbed into the health care and social service network, the presence or absence of informal supports has little to do with utilization of formal services. When access to these services is facilitated by institutions such as enlightened hospital clinics, these elderly are likely to utilize more health care and social services. In the process, this at-risk population is able to maintain life in the community irrespective of their informal networks. The basic assumption that formal social services threaten to replace an active informal support system is an oversimplification which does not take into account a whole host of variables which are related to utilization.

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TABLE 1
SAMPLE CHARACTERISTICS
N=200

Socio-Demographic

Mean Age - 73 years

Gender:	male	31%
	female	69%
Race:	Black	66%
	White	25%
	Other	10%

Marital Status:

Married	17%
Unmarried	83%

Economic Status:

SSI	51%
Medicaid	60%

Household:

Alone	64%
W/others	36%

Family Characteristics:

Childless	31%
No children in proximity	45%

Health and Functional Status:

Report Fair/Poor health	58%
Restricted in activities	57%
In pain	62%
Little energy	50%
Problems with sleeping	46%
Impaired on 3+ ADL/IADL	42%

Utilization of Health and Social Services:

Mean annual clinic visits	11.8
Hospitalized previous year	29%
Use 1 or more formal services	65%
Have Home Health Care worker	35%
Use transportation services	27%
Services arranged by Clinic	65%
Services arranged by family	2%

TABLE 2
Family Structure and Social Supports of Inner-City Elderly
n=200
(by percentage)

Family Supports

	Instrumental Supports			Expressive Supports			Social Contacts (weekly or more)
	Yes	No	N/R[1]	Yes	No	N/R[1]	
Spouse	14%	6%	80%	15%	5%	80%	17%
Child	29%	37%	34%	39%	28%	33%	41%
Sibling	14%	60%	26%	32%	41%	27%	18%
Relative	16%	62%	22%	29%	48%	23%	41%
Friend	29%	63%	8%	57%	35%	8%	72%
Assoc.							66%

Potential Supports

	Call if Ill	Shop	Recuperation
Spouse	3%	11%	14%
Child	31%	24%	19%
Sibling	12%	7%	6%
Relative	14%	7%	7%
Friend	32%	28%	9%
Formal support	2%	11%	25%
No one	7%	7%	18%
Denies need	7%	2%	

[1]No relationship

TABLE 3
The Receipt of Formal and Informal Supports
by Level of Impairment
n=200
(by percent)

	Impaired on 1 or 2 ADL n=116	Impaired on 3 or more ADL n=84	X^2 Total
Instrumental Supports from:			
Spouse	17%	10%	2.2421
Child	24%	37%	3.2290
Sibling	13%	16%	.0934
Relative	11%	23%	3.9102
Friends	31%	27%	.1617
Social Contacts with:			
Spouse	17%	13%	2.219
Child	42%	40%	.0003
Sibling	16%	19%	.0910
Relative	40%	42%	.0196
Friend	72%	71%	.0195
Formal Supports:			
Visiting Nurse	6%	29%	17.2118**
Home Choreworker	7%	72%	87.5610**
Senior Center	35%	39%	0.1776
Transportation	6%	55%	53.9157**
Total Services - mean#	0.655	2.452	

*significant at <.05
**significant at <.001

TABLE 4
Regression of Use of Social Services on Predisposing, Enabling and Need Characteristics

Variables	B	F value	r^2
Predisposing:			
Age	0.00766	.362	
Gender	-0.09202	.277	
Race	-.17760	.550	
Married	.27551	1.104	.0935
Lives Alone	.66864	10.460**	
Enabling:			
Income Adequacy	-.05354	.185	
Clinic Visits	.008	.428	
Satisfaction w/supports	-.16874	8.095**	.1808
Needs:			
Perceived Health	.13095	1.650	
ADL/IADL Status	.20845	99.114***	
No. Times Hospitalized	.36124	3.027	
Family ADL Help	-.02960	.314	.5531

(Adjusted r^2 = .5241, F 19.079, p<.0001)
*p <.05
**p <.01
***p <.001